TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
METROCREST SURGERY CENTER

Respondent Name
INDEMNITY INSURANCE CO OF NORTH AMERICA

MFDR Tracking Number
M4-18-0539-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
OCTOBER 30, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "At this time we are requesting that this claim be paid in accordance with the 2016 Texas Workers Comp Fee Schedule and Guidelines for Ambulatory Surgical Centers."

Amount in Dispute: $1,561.97

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CPT code 29879 was not billed by the surgeon, therefore, we cannot pay the facility for it."

Response Submitted By: Chubb

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 22, 2016	Ambulatory Surgical Care for CPT Code 29881	$0.00	$0.00
	Ambulatory Surgical Care for CPT Code 29879	$1,561.97	$0.00
TOTAL		$1,561.97	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.402, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 291-This code was not billed by the Primary Surgeon.
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - W3-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

1. What is the applicable fee guideline?
2. Is the requestor entitled to reimbursement for the disputed services?

Findings

1. The fee guideline for Ambulatory Surgical Care services is found in 28 Texas Administrative Code §134.402.
2. The requestor is seeking reimbursement of $1,561.97 for CPT code 29879-LT.

   28 Texas Administrative Code §134.402(d) states,

   > For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section.

   According to the explanation of benefits, the respondent denied reimbursement for code 29879 based upon "291-This code was not billed by the Primary Surgeon." In support of the position, the respondent submitted a copy of the surgeons claim that shows only code 29881 was billed.

   On the disputed date of service the requestor billed CPT code 29881 and 29879. These codes are described as:

   - 29881-Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed.
   - 29879-Arthroscopy, knee, surgical; abrasion arthroplasty (includes chondroplasty where necessary) or multiple drilling or microfracture.

   The respondent paid $3,123.93 for code 29881 and it is not in dispute; therefore, it will not be considered further.

   Per 28 Texas Administrative Code §134.402(d), the division refers to the requestor's submitted documentation to determine if the requestor supported billing code 29879.

   The Operative report indicates that the claimant underwent "redacted."

   Based upon the submitted report and code description, the division finds the requestor did not support billing code 29879. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		11/28/2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.